

Pediatric Rehabilitation Services Patient-Caregiver/Staff Agreement

Mason Health providers want to provide your child with the best and safest care possible. Your child was admitted to the Rehabilitation Clinic for treatment to improve his/her developmental skills. During this course of treatment, your care team will work with you and your child to address his/her physical, communication, self care, and/or social-emotional skill development. We aim to achieve the best possible outcome for your child and family. We intend to provide care that is compassionate, respectful, and non-judgmental.

Your care team will work with your child and family to provide the best care for your child to progress developmentally. We will work with each individual family to teach family-centered plans and strategies for targeting developmental progression at home in addition to clinic appointments. In order for your child to make developmental progress in therapy, we need your help and encourage you to complete your home program each week. The home program is critical to your child's progression.

As a critical member of the care team, we ask that you agree to the following:

1. I agree to help set my child's treatment goals and try my best to achieve these goals during my child's course of treatment.
2. I agree to work with my care team to develop the most appropriate treatment plan for my child. I understand that pediatric therapy requires a team consisting of family and therapists. The therapy team will agree to consider and respect culture and family needs when determining recommendations. I agree to respect the therapist's professional opinion regarding appropriate treatment goals, procedures, and home program.
3. I understand that I can discharge my child from therapy at any time. If I choose to leave treatment before the recommended course is finished, I agree to contact the clinic to cancel all appointments. I understand that the therapist may discharge my child based on their professional judgment. I understand that a therapy break may be initiated if my child receives therapy for an extended period, and I understand this is a common component of extended treatment.
4. I understand that consistent attendance is important for my child's progression toward therapy goals. I will make every effort to bring my child to scheduled appointments. If I need to cancel an appointment, I will call by the end of the business day prior to the appointment.
5. I understand that if my child misses three (3) consecutive appointments without prior-day notification (no-show), then my child will be discharged from therapy. A new prescription from the referring provider will be required to resume therapy when my child/family's circumstances allow for consistent attendance. I understand that if a waitlist is in effect at the time of a new prescription, my child will be placed on the waitlist as a new patient. Previous appointment times may not be available when resuming therapy after a discharge.

I acknowledge I have read the above and understand this agreement is in place to ensure the best possible therapy outcome for my child.

Parent/Guardian Signature _____ Date: _____ Time: _____

Patient Label